MOTION FILED

NOV 12 2009

145

(3)

No. 09-430

IN THE

Supreme Court of the United States

RAKESH WAHI, M.D.

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *ET AL.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER AND BRIEF OF *AMICUS CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. IN SUPPORT OF PETITIONER

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608

Counsel for Amicus Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 37.2(b) of the Rules of the Supreme Court, the Association of American Physicians and Surgeons, Inc. ("AAPS") respectfully moves this Court for leave to file the accompanying brief *amicus curiae* in support of the Petition for Writ of Certiorari submitted by Petitioner Rakesh Wahi. Respondents have not granted consent, thereby making this motion necessary.

AAPS is a non-profit, national group of thousands of physicians founded in 1943, dedicated to defending the patient-physician relationship and free enterprise in medicine. AAPS has filed *amicus curiae* briefs in several federal appellate cases concerning sham peer review, and on many other important medical issues. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief); *Springer v. Henry*, 435 F.3d 268, 271 (3d Cir. 2006) (citing an AAPS *amicus* brief in the first paragraph of the decision); *United States v. Rutgard*, 116 F.3d 1270 (9th Cir. 1997) (reversal of a sentence as urged by an *amicus* brief submitted by AAPS).

There is a growing misuse of peer review commonly known as "sham peer review." Sham peer review consists of manipulation of peer review to eliminate physicians for economic or other improper reasons. Accountability for wrongdoing is essential to deter and guard against sham peer review, and the lower court's standard for immunizing such wrongdoing by hospitals with respect to physicians has a disastrous effect on health care. AAPS has members who have been injured by bad faith or "sham" peer review, simi-

lar to what has occurred here. Many good physicians have lost their ability to practice medicine, and their patients have lost their access to the physicians of their choice, because of these sham peer reviews.

The Petition has national implications for the delivery of quality medical care and the integrity of professional peer review. Patients suffer when physicians are removed from hospital staffs, and their careers ruined, based on improper motives. When immunity shields and encourages hospitals to engage in sham peer review, as occurred here, the chilling effect on good physicians is catastrophic. Few physicians will speak out in favor of patient care and preservation of life if it means risking their careers at the hands of a biased hospital committee.

AAPS submits the attached brief to explain the national significance of how the decision below unjustifiably encourages "sham peer review" by hospitals. In this brief AAPS also demonstrates the importance of restoring integrity to peer review for the benefit of medical care nationwide.

For the above reasons, AAPS respectfully requests that this motion for leave to file the attached brief *amicus curiae* be granted.

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
Counsel for the Association
of American Physicians &
Surgeons, Inc.

QUESTIONS PRESENTED

1. The Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, provides a hospital immunity from monetary damages for disciplining a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, the Act allows disciplining "immediately" – that is, *before* notice and a hearing or other "fair" procedures – only where "failure to take such an action may result in an imminent danger to the health of any individual." § 11112(c). Did the court below err in holding, in conflict with four other circuits, that a hospital can obtain immunity for disciplining a doctor immediately – before notice and a hearing – where the hospital concedes that it did not find or rely upon the possibility of imminent danger?

2. Under the Act, may an immunity determination be made by a jury, as the First and Tenth Circuits hold, or is a jury forbidden from making such a determination, as the Eleventh Circuit and Colorado Supreme Court hold – and as the Fourth Circuit effectively held here?

TABLE OF CONTENTS

Pages

MOTION FOR LEAVE TO FILE i
QUESTIONS PRESENTED iii
TABLE OF CONTENTS iv
TABLE OF AUTHORITIES v
INTEREST OF *AMICUS CURIAE* 1
SUMMARY OF ARGUMENT 2
ARGUMENT 5
I. A CRISIS OF NATIONAL SIGNIFICANCE RESULTS FROM THE "UNCONVENTIONAL STANDARD" APPLIED BY THE FOURTH CIRCUIT BELOW, WHICH IMPEDES COMPETITION, FRUSTRATES INNOVATION, AND INTERFERES WITH QUALITY MEDICAL CARE 7
II. THE PETITION SHOULD BE GRANTED TO CURB THE LEGAL ABUSES ARISING FROM SHAM PEER REVIEW 13
III. HCQIA IMMUNITY DOES NOT EXTEND TO A SUMMARY SUSPENSION TAKEN WITHOUT IMMINENT DANGER, NOTICE, OR A PRIOR HEARING, AND THE DECISION BELOW THEREBY INTERFERES WITH FEDERALISM 19
CONCLUSION 24

TABLE OF AUTHORITIES

Pages

Cases

Abshire v. Cline, 193 W. Va. 180, 455 S.E.2d 549 (1995) 20-21

Armstrong v. *Manzo*, 380 U.S. 545 (1965) 20

Clark v. Columbia/HCA Info. Servs., 117 Nev. 468, 25 P.3d 215 (Sup. Ct. Nev. 2001) 23

District of Columbia v. Heller, 128 S. Ct. 2783 (2008) 2

Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council, 485 U.S. 568 (1988) 21

Gabaldoni v. Washington County Hosp. Ass'n, 250 F.3d 255 (4th Cir. 2001) 8

Goldberg v. Kelly, 397 U.S. 254 (1970) 20

Gonzales v. Oregon, 546 U.S. 243 (2006) 21

Gonzales v. Raich, 545 U.S. 1 (2005) 23

Grannis v. *Ordean*, 234 U.S. 385 (1914) 20

Harris v. Bradley Mem. Hosp. & Health Ctr., 2005 Conn. Super. LEXIS 1401 (Conn. Super. Ct. May 19, 2005) 23-24

Horner v. Dep't of Mental Health, Mental Retardation, & Substance Abuse Servs., 268 Va. 187 (2004) 12

Linder v. United States, 268 U.S. 5 (1925) 22

Poliner v. Tex. Health Sys., 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (2009) 16-17

Premiere Network Servs. v. SBC Comm., 440 F.3d 683 (5th Cir. 2006) 21

SEC v. Sloan, 436 U.S. 103 (1978) 20

Springer v. Henry, 435 F.3d 268 (3d Cir. 2006) ...i

Stenberg v. Carhart, 530 U.S. 914 (2000)..... i, 2

United States v. Bass, 404 U.S. 336 (1971) ..22-23

United States v. Lopez, 514 U.S. 549 (1995) .22-23

United States v. Rutgard, 116 F.3d 1270 (9th Cir. 1997) i

Wahi v. Charleston Area Med. Center, 453 F. Supp. 2d 942 (S.D. W.Va. 2006), *aff'd*, 562 F.3d 599 (4th Cir. 2009) 20

Wahi v. Charleston Area Med. Center, 562 F.3d 599 (4th Cir. 2009) ..... *passim*

Will v. Michigan Dep't of State Police, 491 U.S. 58 (1989) 21

Statute and Legislative History

42 U.S.C. §§ 11101-11152..... iii

42 U.S.C. § 11101(4) 20

42 U.S.C. § 11112(a) ..... iii, 19

42 U.S.C. § 11112(c)..... iii

Articles and Treatise

Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005) 9

Jeff Chu, "Doctors Who Hurt Doctors," Time 52 (Aug. 15, 2005) 10

H. Friendly, "Federalism: A Foreword," 86 Yale L. J. 1019 (1977) 22

Lawrence Huntoon, M.D., Ph.D., "Tactics Characteristic of Sham Peer Review," *Journal of American Physicians and Surgeons* 64 (Fall 2009) 13-14, 17

Lawrence Huntoon, M.D., Ph.D., "Abuse of the 'Disruptive Physician' Clause," *Journal of American Physicians and Surgeons* 68 (Fall 2004) 9-10

John Minarcik, M.D., "Sham Peer Review: a Pathology Report," *Journal of American Physicians and Surgeons* 121 (Winter 2004) 9

William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000) 10

Scott Plantz, M.D., *et al.*, "A National Survey of Board-Certified Emergency Physicians: Quality of Care and Practice Structure Issues," 16 *Am. J. of Emerg. Med.* 1 (Jan. 1998) 11

Bob Stuart, "Court Rules for Whistleblower," *News Virginian* (June 16, 2004) 12

William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," *Journal of American Physicians and Surgeons* 125 (Winter 2005) 9

David Townsend, "Hospital Peer Review Is a Kangaroo Court," Medical Economics 133 (Feb. 7, 2000) 9

Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003) 9

Gail Weiss, "Is Peer Review Worth Saving?" Medical Economics (Feb. 18, 2005) 9

G. Wood, *The Creation of the American Republic, 1776-1787* (1969) 22

John Zicconi, "Due Process or Professional Assassination?" Unique Opportunities (March/April 2001) 9

Internet

http://www.allianceforpatientsafety.org/hs2.pdf (viewed 11/6/09) 18

http://www.jpands.org/vol10no4/summers.pdf (viewed 11/6/09) 9

http://www.jpands.org/vol14no3/huntoon.pdf (viewed 11/6/09) 14

http://www.jpands.org/vol9no3/huntoon.pdf (viewed 11/6/09) 10

http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/6/09) 9

http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/6/09) 9

http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/6/09) 9

http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/6/09) 9

No. 09-430

IN THE
Supreme Court of the United States

RAKESH WAHI, M.D.

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *ET AL.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

INTEREST OF *AMICUS CURIAE*[1]

The Association of American Physicians and Surgeons, Inc. ("AAPS"), founded in 1943, is a non-profit, national group of thousands of physicians. AAPS has members who have suffered from bad faith

[1] Timely notice for this brief was provided in compliance with Rule 37.2(a) of the Supreme Court of the United States. Respondents did not consent and hence an accompanying motion is filed with this brief. Pursuant to its Rule 37.6, counsel for *amicus curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus*, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

peer review by hospitals, also known as "sham peer review," as retaliation for competing with a hospital, practicing innovative medicine or simply standing up on behalf of patients. In many cases the sham peer reviews are initiated because a talented physician posed a competitive threat to a hospital, or to colleagues who are powerful at a hospital.

AAPS is dedicated to defending the practice of private and ethical medicine so that physicians may best serve their patients without interference by third parties. AAPS has filed *amicus curiae* briefs in numerous cases before the United States Supreme Court and federal Courts of Appeals, and its submissions have been cited in opinions. *See, e.g.*, *District of Columbia v. Heller*, 128 S. Ct. 2783, 2860 (2008) (Breyer, Stevens, Souter and Ginsburg, JJ., dissenting); *Stenberg v. Carhart*, 530 U.S. 914, 933 (2000).

The issues presented in this case are of national importance, affecting virtually every hospital in the nation, every physician at every hospital, and every one of their patients. *Amicus* has a direct and vital interest in the issues presented by the Petition, based on the harmful effect on the practice of medicine and the quality of patient care that results from judicially created – and statutorily unjustified – immunity for bad faith peer review.

SUMMARY OF ARGUMENT

Bad faith or "sham" peer review is an issue of enormous national importance. It is a pervasive national problem that impedes medical innovation, interferes with beneficial competition, and punishes extraordinarily good medical care. In no industry other than health care can a self-interested rival

thwart competition with impunity and destroy good professionals with abandon, while enjoying full legal immunity for the wrongdoing.

In this case, the Respondent Charleston Area Medical Center (CAMC) concedes it did not rely on any imminent danger in summarily suspending Petitioner Wahi's privileges. *See* Petition at 25. But imminent danger is the only legitimate and statutorily justified basis for taking such draconian, emergency action. The real motivation for the CAMC to take such drastic action was apparently just as Petitioner Wahi alleged: "CAMC's decisions to suspend [Petitioner Wahi] and deny his application for reappointment were taken in bad faith to prevent competition by monopolizing the field of cardiac surgery in the region and to prevent him from practicing medicine." *Wahi v. Charleston Area Med. Center*, 562 F.3d 599, 605 (4th Cir. 2009) (Pet. at 10a).

Sham peer review, which is at the heart of this case, works as follows. A hospital seeking to destroy a potential competitor finds a pretext for revoking or restricting the physician's medical privileges, as occurred here. That results in an entry against the physician in the National Practitioner Data Bank, as occurred here, which is the equivalent of a professional blacklist and a death-sentence to the physician's career. *Id.* at 603 (Pet. at 7a). The physician, as in the case of Petitioner Rakesh Wahi, M.D., is then unable to obtain hospital privileges *anywhere*. Physicians, who have invested the best years of their lives and hundreds of thousands of dollars in their education and training, cannot afford to risk being destroyed by sham peer review. The chilling effect of granting immunity to wrongdoing in this process is

unfathomable; it utterly destroys competition and innovation in everything affected by hospitals, which is nearly the entire health care system.

Lower courts have developed an unjustified standard that fully allows bad faith by hospitals without accountability. A hospital need only find a single mistake in the physician's practice – something all physicians have, as no one is perfect – and this satisfies the purely objective standard adopted by the courts for affirming a hospital's revocation or limitation of privileges.

In this case, the CAMC, an affiliation of seven hospitals in West Virginia, suspended Petitioner Wahi and denied his application for reappointment for one likely reason: economics rather than quality of care. The hospital's basis for denying Petitioner Wahi reappointment was *not* for a medical error, but for his provision of care (an operation) to a high risk patient. *See* J.A. 586. Hospitals intimidate physicians into withholding or rationing care from the most sickly (and most costly) patients in this manner. After all, hospitals are economic entities motivated by money as much as any other business. But only hospitals enjoy a legal standard granting them full immunity for their wrongdoing in destroying a professional. What occurred in this case is playing out in nearly every hospital in this nation, and the cost of allowing hospitals to continue to engage in bad faith peer review to suppress competition, innovation and quality care is astronomical.

The appellate court below adopted and applied a particularly "unconventional standard" to deny accountability for this sham peer review and thereby prevent Wahi from obtaining his full day in court.

The appellate court has split with other Circuits on the proper standard for reviewing allegations of bad faith peer review. This Court should grant the Petition for Writ of Certiorari to correct this especially "unconventional standard" and restore accountability for wrongdoing by hospitals which take action against professionals who may seek to compete against them, or may develop a technique that threatens the hospital's revenue, or may simply stand up for the care of patients at the hospital.

The Petition should be granted due to the national importance of this issue. The misuse by a hospital of peer review at issue in this case is pervasive in the health care industry.

The health care industry consumes one-sixth of our nation's economy and has dominated national politics for most of 2009. Costs are increasing faster than the quality of care. Basic economic principles dictate that high prices are typically the result of inadequate competition, and that is certainly the case in the profitable hospital industry. With increasing frequency, when there is even a hint of competition against a hospital by a physician on its staff, the hospital initiates a sham peer review. The precedent set below unjustifiably immunizes the hospital from accountability and liability for its bad faith in destroying potential competitors.

ARGUMENT

At issue here is the particularly "unconventional standard" adopted by the Fourth Circuit and implemented below in granting summary judgment to a hospital for destroying a professional and potential competitor through bad faith peer review. 562 F.3d

at 607 (quotations omitted). Petitioner Wahi posed a potentially competitive threat to CAMC, and it responded by summarily suspending his privileges and reporting him to the National Practitioner Data Bank, destroying his surgical career. Instead of applying the express prohibition on HCQIA immunity for summary suspensions in the absence of imminent danger, the court below upheld the hospital's discipline and prevented the issue from going to a jury.

This Court should grant the Petition for three reasons. First, there is national significance to the application below of an especially unconventional standard that immunizes bad faith peer review even when it is anticompetitive and perpetrated without a hearing or even notice. By protecting wrongdoing by hospitals in initiating peer review and falsely reporting competitors to the National Practitioner Data Bank as though they are bad doctors, the standard adopted by the appellate court worsens the chilling effect imposed by hospitals on medical innovation by potential competitors who reasonably fear retaliation.

Second, the Petition should be granted to curb growing legal abuses encouraged by judicial immunity granted to bad faith peer review of physicians. The hospital bar is increasingly relying on contrivances and sensationalism to destroy physicians who might compete with a hospital, and courts below are repeating tabloid-like allegations as though they have merit. This case features a cardio-thoracic physician as Petitioner, and despite being in a high-risk field his medical record is remarkably clean. But that did not stop the hospital from exploiting its immunity with trumped-up and almost *National Enquirer*-style allegations, which were then repeated by the court below as though they were true.

Finally, a physician's right to a hearing and, in the absence of imminent danger, adequate notice *before* suspension, are essential to deter and inhibit sham peer review. The granting of blanket immunity below in the absence of the requisite notice or a prior hearing – and not even an *ex post facto* hearing – has dire consequences for the entire health care field. The statute does not support granting hospitals such sweeping immunity for their wrongdoing against potential competitors.

Proper application of HCQIA procedures to hospital peer review arises in nearly every hospital in the nation, and affects most of the hundreds of thousands of physicians having hospital privileges. In light of the enormous national significance, the Petition should be granted.

I. A CRISIS OF NATIONAL SIGNIFICANCE RESULTS FROM THE "UNCONVENTIONAL STANDARD" APPLIED BY THE FOURTH CIRCUIT BELOW, WHICH IMPEDES COMPETITION, FRUSTRATES INNOVATION, AND INTERFERES WITH QUALITY MEDICAL CARE.

It should be axiomatic that summary suspension of a physician's privileges – which plainly has the effect of destroying his reputation and career – requires a showing of imminent danger before immunity can insulate the decision from accountability. Four Circuits have so held, and nothing in the Health Care Quality Immunity Act (HCQIA) suggests otherwise.

Yet the appellate court below split with these authorities and turned HCQIA on its head by holding otherwise. It adopted a version of a HCQIA standard that it describes as "unconventional", and its holding essentially gives hospitals *carte blanche* to destroy

any physician who might become an obstacle to hospital profits. This creates not only a circuit split,[2] but also a crisis of national significance, as no physician can be innovative or competitive without fearing an unjustified summary suspension, which is then reported to the National Practitioner Data Bank with devastating reputational effect. Such blacklisting typically permanently prevents the physician from obtaining hospital privileges again. Petitioner Wahi, a superb cardio-thoracic surgeon, has been destroyed and his patients have been deprived of his superior care.

The decision below extends a prior ruling by Fourth Circuit beyond all statutory limits, to significant national detriment. In *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255 (4th Cir. 2001), a physician enjoyed procedural safeguards that are not present here. There the physician received a full hearing, unlike here. The "presumption of immunity" embraced by the *Gabaldoni* Court, *see id.* at 260, makes little sense where, as here, there was a summary suspension without any imminent danger and there was no subsequent hearing at all. In opening the door to meritless summary suspensions and providing full immunity to hospitals for such wrongdoing, the decision below conflicts with the other circuits and causes a problem of national significance.

---

[2] The circuit splits created by the decision below are described well in Points I.B and II of the Petition. Briefly, the decision below creates a circuit split over whether HCQIA immunity attaches to a summary suspension imposed without imminent danger, and widens another split over whether HCQIA bars a jury trial.

Medical literature has frequently described the abuses perpetrated by the hospital industry against good physicians under the guise of peer review, and the aberrant decision below opens the floodgates to more sham peer review. *See e.g.*, Gail Weiss, "Is Peer Review Worth Saving?" Medical Economics (Feb. 18, 2005);[3] Steve Twedt, "The Cost of Courage: How the Tables Turn on Doctors," *Pittsburgh Post-Gazette* A1 (Oct. 26, 2003);[4] John Zicconi, "Due Process or Professional Assassination?" Unique Opportunities (March/April 2001);[5] David Townsend, "Hospital Peer Review Is a Kangaroo Court," Medical Economics 133 (Feb. 7, 2000).

Many additional medical journal articles have detailed the abuses of peer review, which continue to worsen. *See, e.g.*, William Summers, "Sham Peer Review: A Psychiatrist's Experience and Analysis," *Journal of American Physicians and Surgeons* 125 (Winter 2005);[6] Roland Chalifoux, Jr., M.D., "So What Is a Sham Peer Review?", 7 *Medscape General Medicine* (No. 4) 47 (2005); John Minarcik, M.D., "Sham Peer Review: a Pathology Report," *Journal of American Physicians and Surgeons* 121 (Winter 2004);[7] Lawrence Huntoon, M.D., Ph.D., "Abuse of the 'Disruptive Physician' Clause," *Journal of Ameri-*

---

[3] http://www.memag.com/memag/article/articleDetail.jsp?id=147405 (viewed 11/6/09)

[4] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/6/09)

[5] http://www.uoworks.com/pdfs/feats/PEERREVIEW.pdf (viewed 11/6/09)

[6] http://www.jpands.org/vol10no4/summers.pdf (viewed 11/6/09)

[7] http://www.jpands.org/vol9no4/minarcik.pdf (viewed 11/6/09)

can Physicians and Surgeons 68 (Fall 2004);[8] William Parmley, "Clinical Peer Review or Competitive Hatchet Job," 36 *Journal of the American College of Cardiology* 2347 (2000).

As courts increasingly immunize hospitals for wrongdoing in peer review, the epidemic of bad faith review of potential competitors worsens. Such wrongful conduct interferes with quality medical care and impedes the benefits of competition and free enterprise. "Sham peer review" is not "peer review" at all, but is tortious conduct labeled "peer review" by hospitals in order to exploit a judicially created immunity. The decision below should be reversed to ensure that hospitals do not continue to summarily suspend physicians – thereby destroying their careers and chilling innovation and competition – without adequate basis.

In an economic sense, it is not surprising that hospital administrators hired to maximize profits would exploit their immunity for the benefit of shareholders, at the expense of patient care. And if this immunity were actually created by Congress, then the courts might leave the problem for Congress to resolve. But Congress did not create such sweeping immunity in HCQIA or any other federal law. Moreover, principles of federalism militate against such a massive interference with state law in this field.

When courts expand immunity to sham peer review the "system is too open to manipulation and needs reform." Jeff Chu, "Doctors Who Hurt Doctors," Time 52 (Aug. 15, 2005) (citing the Association of American Physicians and Surgeons). In medicine

---

[8] http://www.jpands.org/vol9no3/huntoon.pdf (viewed 11/6/09)

as in any industry, a sweeping grant of immunity to one side is as disastrous as it is unjustified. For physicians who truly are a danger to patients, state medical boards can and will restrict or revoke their licenses to practice medicine. Likewise, they can weed out complaints filed under questionable motivations, such as when the West Virginia state medical board repeatedly exonerated Dr. Wahi. In addition, patients themselves will abandon a bad physician, just as shoppers will not continue buying bad products. If a hospital wishes to rid itself of a negligent physician, it is always free to do so regardless of whether it has special immunity under federal law. But immunity for sham peer review by a hospital is inappropriate.

Unchecked retaliation against innovators and outspoken physicians is a growing problem. Nearly 25% of physicians who reported concerns with patient care, which could include denial of care to handicapped infants or those in persistent vegetative states, suffered threats to their jobs. Scott Plantz, M.D., *et al.*, "A National Survey of Board-Certified Emergency Physicians: Quality of Care and Practice Structure Issues," 16 *Am. J. of Emerg. Med.* 1, 2-3 (Jan. 1998). Steve Twedt of the Pittsburgh Post-Gazette has reported on the same problem in his series beginning Oct. 26, 2003, entitled "Cost of Courage."[9] His articles showed how retaliation occurs nationwide, describing in detail the experiences of 25 physicians and a nurse, who suffered from actions adverse to their careers after they tried to improve care at their respective institutions.

---

[9] http://www.post-gazette.com/pg/03299/234499.stm (viewed 11/6/09)

Dr. Harry Horner is a physician who had to fight all the way to the Supreme Court of Virginia to obtain reinstatement after retaliation for complaining about poor care at the hospital. *See Horner v. Dep't of Mental Health, Mental Retardation, & Substance Abuse Servs.*, 268 Va. 187 (2004). Though difficult to glean from the reported decision, Dr. Horner was exposing the poor care of patients when an administrator at Western State Hospital accused him of violating another employee's right to confidentiality. The administration of Dr. Horner's hospital added accusations that he was guilty of abuse and neglect because he failed to wear gloves while dressing a wound on a patient's foot. *See* Bob Stuart, "Court Rules for Whistleblower," *News Virginian* (June 16, 2004). Such pretextual allegations have become common; judicial relief for it, however, is vanishing.

The chilling effect of a grant of immunity to hospitals in the absence of a hearing is clear: destroy the career of one physician, and hundreds or thousands of physicians will refrain from speaking out or competing against the perpetrators. The result is a crisis of national significance.

II. THE PETITION SHOULD BE GRANTED TO CURB THE LEGAL ABUSES ARISING FROM SHAM PEER REVIEW.

The overly broad immunity for bad faith allegations in peer review has resulted in legal abuses, and repetition by courts of contrivances as though they were factual. Often the allegations are even designed, with the help of the hospital bar, to have a superficial sensationalism in order to shock the layman. Peer review is becoming tabloid-like, with the science of medicine being replaced by what might shock a judge or newspaper reader when the mistakes are actually harmless or not even the physician's responsibility, and hospitals have an incentive in ruining good physicians who might compete. A grant of the Petition is necessary to curb the deceitful allegations and limit their repetition in court decisions. Obvious logical flaws and transparent sensationalism (for the layman) should no longer be tolerated in proceedings under HCQIA.

The leading medical expert in this field recently published an expose of the pattern of deception by hospitals to exploit the especially "unconventional standard" of immunity adopted by the court below. "The tactics used by hospitals and others in conducting a sham peer review are remarkably similar throughout the country." Lawrence Huntoon, M.D., Ph.D., "Tactics Characteristic of Sham Peer Review," *Journal of American Physicians and Surgeons* 64

(Fall 2009).[10] Dr. Huntoon emphasized about a dozen deceptive tricks played by hospitals, and several of these familiar deceits made it into the decision below. The decision below should be reversed on this ground alone.

For example, the court below disparaged Petitioner Wahi by saying he is "not a first-time offender." 562 F.3d at 613 (Pet. 29a). But Petitioner Wahi was exonerated every time he was falsely accused of something. The CAMC exonerated him in its own investigation, and the West Virginia medical board exonerated him three different times when it was prompted to investigate him. The fact that the hospital repeatedly asserted baseless, trumped-up charges is not an indictment of the accused, but of the accuser. It is evidence of improper use of peer review rather than improper practice of medicine. For the court below to use the fact of repeated review of a physician – while omitting that he was exonerated – is an illustration of how misguided its standard is.

Another example of a deceptive argument made by hospitals and which has superficial appeal – but which is logically nonsensical – is described by Dr. Huntoon as the "Numerator-Without-Denominator Tactic":

> Although the numerator-without-denominator tactic can be used against any physician, it is most commonly used against surgeons. Hospitals that

---

[10] http://www.jpands.org/vol14no3/huntoon.pdf (viewed 11/6/09) (Neither AAPS nor its counsel has any control over the content of this journal; Dr. Huntoon has served as an expert in sham peer review cases, and has presented the material in this article as speeches accredited for Continuing Medical Education (CME) credits).

> use this tactic typically select cases that are specifically designed to highlight complications or negative outcomes. The selection of cases often falls outside the routine protocol used for selecting cases for review of physicians practicing at the hospital. The hospital then presents this select group of cases to peer reviewers as evidence that the targeted physician is a bad doctor or provides unsafe care.

Id. at 64. The defect of this approach – exploited by the hospital bar – is that statistically insignificant mistakes in a physician's record are meaningless for evaluating his record. Dr. Huntoon explained this further:

> Hospitals that use this tactic specifically omit the denominator (how many cases of that type the physician has performed over a period of time), thus eliminating the possibility of calculating a complication rate that could be used to make a fair comparison with statistics of other colleagues, or statistics published in medical literature. Virtually all surgeons, of course, experience complications, and the only surgeons who have zero complications are those who do not perform surgery, or who do not report their complications.

Id. at 65.

This fallacious approach of sham peer review was embraced below. The lower court adopted and applied a standard that encourages dismissal of cases no matter how small the "numerator" is and no matter how large the omitted "denominator" is in the hospital allegation. Respondent CAMC could not even find an adverse outcome to use against the cardio-thoracic surgeon Petitioner Wahi, so instead it relied on non-substantive allegations like "Failure to

obtain a proctor when required to do so." 562 F.3d at 611 (Pet. at 25a). Where is the "denominator" for that apparently inconsequential infraction? On this meager basis a surgeon's career can be destroyed? There is no indication of how often this occurred or what its significance, if any, was. In adopting a standard that allows discipline for this, the court's precedent violates the maxim of *de minimis non curat lex* (the law does not concern itself with trifles). Yet such specious accusations against good physicians and surgeons are encouraged by the standard adopted below.

No court would take seriously an allegation that an attorney was incompetent based on a statistic that he lost a certain number of cases without first asking what the denominator is: how many cases did he handle overall, and how difficult were those cases? But in a precedent cited favorably below, the Fifth Circuit took that defective approach in affirming reputation-ending discipline of a physician. *See Poliner v. Tex. Health Sys.*, 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S. Ct. 1002 (2009).

In *Poliner*, the Fifth Circuit held in favor of a hospital despite proof of its bad faith in disciplining an innovative cardiologist. That court used several statistically insignificant examples dredged up by the hospital: a harmless rash, an unpreventable death, inadequate hospital diagnostic equipment, and nursing staff errors. The five cases at the heart of that decision were plainly contrived, as most consisted of patients who performed well, and included inevitable complications (like a rash) that were no fault of the targeted physician. *Id.* at 371-72. But as in other sham peer review cases, the hospital bar prefers examples designed to inflame an unjustified shock in a

layman (especially a court), rather than a bona fide medical deficiency. Operating on the correct artery but missing a second clogged one (due to equipment failure) was a medically harmless and statistically insignificant allegation against Dr. Poliner, but a claim having an exaggerated effect on a layman. *Id.* at 371 n.9 (repeating the allegation of a missed artery while holding that "for our purposes, it does not matter" whether the artery allegation was meaningful). These types of titillating but medically insignificant allegations now dominate peer review cases in judicial proceedings.

Another page from the hospital playbook for destroying a physician-competitor is to smear him as somehow being "disruptive". Huntoon, "Tactics Characteristic of Sham Peer Revew," *Journal of American Physicians and Surgeons, supra,* at 65. The decision below accepted that allegation at face value also: there were "[m]ultiple incident reports surrounding bizarre professional behavior and inappropriate personal behavior among nursing staff." 562 F.3d at 611 (Pet. at 25a). Nurses are employees of a hospital, and it is commonplace now for hospital administrators to arrange for these "incident reports" when they want to target a potential competitor for retaliation. This implausible accusation of "bizarre" and "inappropriate" behavior looks more like headline puffing found in the *National Enquirer* than an earnest evaluation of a surgeon's abilities and record. The hospital bar encourages accusations that shock a court (and newspapers), despite a lack of medical significance. CAMC's baseless assertion of "bizarre" conduct with nurses illustrates its bad faith in trying to frame a good physician. Yet the standard adopted below

encourages courts to accept these meritless and far-fetched charges at face value.

The Petition should be granted to curb the pattern of legal maneuvering and artful alleging with respect to what should be an honest medical evaluation of a professional's record of performance. Lower courts now repeat superficial accusations made by the hospital bar as though they have medical significance, when they do not. If the CAMC's specious allegations here demonstrate anything at all, they illustrate how strikingly clean Petitioner Wahi's record has been in the high-risk field of cardio-thoracic surgery.

The standard adopted below by the Fourth Circuit to shield accountability for sham peer review leads to an inappropriate grant of immunity to hospitals for contrived, insignificant accusations against physicians. The citation of trivial issues that are common to every busy professional are all-too-often accepted by lower courts as proof that the hospital was justified, and the decision below encourages this.

Distorted, shock-provoking assertions by hospitals in peer review have become commonplace. There is a thriving hospital bar that perfects the art of making a good physician look bad to the uninformed. The leading law firm for hospitals, Horty & Springer, actually conducts special seminars at luxurious resorts for hospital administrators, to teach them how to use sham peer review as a way of "[d]ealing with economic competition from medical staff members."[11] The sham peer review of Petitioner Wahi is right out of this playbook.

---

[11] http://www.allianceforpatientsafety.org/hs2.pdf (viewed 11/6/09)

Physicians reasonably expect judicial review to be as logical as medicine and science are. But the lower court's expansive and erroneous implementation of the especially "unconventional standard" for immunity encourages more bad faith accusations, which then spill into judicial decisions. The Petition should be granted to curb these legal distortions.

III. HCQIA Immunity Does Not Extend to a Summary Suspension Taken Without Imminent Danger, Notice, or a Prior Hearing, and the Decision Below Thereby Interferes with Federalism.

The court below erred in conferring HCQIA immunity on a summary suspension taken without imminent danger, without proper notice, and without providing a prior (or even a subsequent) hearing to Petitioner. The adoption below of such sweeping immunity interferes with well-settled principles of federalism.

HCQIA expressly requires adequate notice and hearing procedures:

> "For purposes of the protection set forth in section 411(a), a professional review action must be taken – ... after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances."

42 U.S.C. § 11112(a) & (a)(3). CAMC concedes that there was no imminent danger to justify the summary suspension, that no prior notice was provided to Petitioner Wahi, and that a hearing was never held.

See Petition at 25; *Wahi v. Charleston Area Med. Center,* 453 F. Supp. 2d 942, 947 (S.D. W.Va. 2006), *aff'd*, 562 F.3d 599 (4th Cir. 2009).

This Court has noted in various contexts how notice and a hearing are essential parts of basic due process, and Congress cannot be presumed to allow immunity to attach in an absence of those essential safeguards. Justice Brennan observed in the securities context, for example, that even a short suspension "without notice or hearing so obviously violates fundamentals of due process and fair play that no reasonable individual could suppose that Congress intended to authorize such a thing." *SEC v. Sloan*, 436 U.S. 103, 123-24 (1978) (Brennan, J., concurring). "The fundamental requisite of due process of law is the opportunity to be heard." *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970) (quoting *Grannis* v. *Ordean*, 234 U.S. 385, 394 (1914)). In emphasizing the importance of adequate advance notice, the Court has stressed that "[t]he hearing must be 'at a meaningful time and in a meaningful manner.'" *Id.* (quoting *Armstrong* v. *Manzo*, 380 U.S. 545, 552 (1965)).

Nothing in HCQIA authorizes immunity for a summary suspension taken without imminent danger, notice and a hearing. In its Preamble, HCQIA limits its purpose to immunize against "[t]he threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, [which] ***unreasonably discourages physicians from participating in effective professional peer review***." 42 U.S.C. § 11101(4). Notice and a hearing are fundamental aspects of due process under both West Virginia and federal law. *See, e.g., Abshire v. Cline*, 193 W. Va. 180, 183, 455 S.E.2d 549, 552

(1995) (emphasizing that a hearing is a "fundamental right to due process").

Without a clear statutory mandate, Congress should not be presumed to have preempted due process protections, particularly in the traditionally local domain of medical practice. Where, as here, the dispute concerns "the usual constitutional balance between the states and the federal government," then statutory construction requires that Congress "must make **unmistakably clear** its intention to do so in the statute's language." *Premiere Network Servs. v. SBC Comm.*, 440 F.3d 683, 690 n.8 (5th Cir. 2006) (citing *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 65 (1989) and *Gonzales v. Oregon*, 546 U.S. 243 (2006), emphasis added). Congress did not make it "unmistakably clear" in HCQIA that it preempts traditional state-law rights to notice and a hearing. Nothing supports such a massive expansion in federal power over the medical profession. Where "Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it," state law must remain applicable. *Gonzales v. Oregon*, 546 U.S. at 275.

The Supreme Court has emphasized that "where an otherwise acceptable construction of a statute would raise serious constitutional problems, [courts shall] construe the statute to avoid such problems unless such construction is plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp. v. Fla. Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988). The expansion by the decision below in the scope of HCQIA immunity causes a constitutional problem: it would lead to massive disruption of state law with respect to hospital administration.

This disruption would adversely affect all patients. Medical care is essential to nearly every American, and is the source of numerous controversial local issues from abortion to end-of-life care to so-called medical use of marijuana. Wholesale federal preemption of state law under an expanded HCQIA immunity with respect to hospital administration would violate well-established principles of federalism. As Justice Kennedy has observed:

> [F]ederalism was the unique contribution of the Framers to political science and political theory. Though on the surface the idea may seem counterintuitive, it was the insight of the Framers that freedom was enhanced by the creation of two governments, not one.

United States v. Lopez, 514 U.S. 549, 576 (1995) (Kennedy, J., concurring) (citing H. Friendly, "Federalism: A Foreword," 86 Yale L. J. 1019 (1977) and G. Wood, *The Creation of the American Republic, 1776-1787*, pp. 524-532, 564 (1969)).

Nationwide, hospitals seek to extend HCQIA immunity beyond sensible limits in a manner that would lead to federal control over all of medicine. This is contrary to precedent and congressional action. This Court has emphasized that "[o]bviously, direct control of medical practice in the States is beyond the power of the Federal Government." *Linder v. United States*, 268 U.S. 5, 18 (1925). At no time has Congress attempted to alter state jurisdiction over medicine, despite the urgings of hospitals. "Unless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance." *United States v. Bass*, 404 U.S. 336,

349 (1971). Congress never authorized such a complete disregard of state law for medical practice, an area in which "[s]tates lay claim by right of history and expertise." *Gonzales v. Raich*, 545 U.S. 1, 48 (2005) (O'Connor, J., dissenting) (quoting *Lopez,* 514 U.S. at 583 (Kennedy, J., concurring)).

The Supreme Court of Nevada has already concluded that there are meaningful limits on the scope of immunity under HCQIA. This has benefited Nevadan patients and physicians alike. *See Clark v. Columbia/HCA Info. Servs.,* 117 Nev. 468, 25 P.3d 215 (Sup. Ct. Nev. 2001). There the court denied HCQIA immunity to the hospital (HCA) for revoking a physician's privileges based upon the pretext of disruptive behavior by the physician. In reversing a grant of summary judgment to the hospital by the court below, the court held that "the board is not entitled to immunity as a matter of law." 117 Nev. at 480, 25 P.3d at 223. That court found that the real reason for the sham peer review against the physician was his filing of reports critical of the hospital.

Similarly, a state court in Connecticut has rejected the insatiable demand of hospitals for complete federal immunity. In *Harris v. Bradley Mem. Hosp. & Health Ctr.*, 2005 Conn. Super. LEXIS 1401 (Conn. Super. Ct. May 19, 2005), the court held that HCQIA does not immunize a hospital against all claims for damages because not all summary suspensions qualify as peer review under HCQIA. That court decided:

> After a review of the case law and the evidence, presented by the plaintiff, the court concludes that the plaintiff engaged in more than one professional review action and that the plaintiff has demonstrated the existence of a genuine issue of materi-

al fact concerning whether one of those actions satisfied the statutory requirements for immunity.

Id. at *15 · *16.

Neither the plain meaning of HCQIA nor well-established principles of federalism support the decision below, which applied immunity to a summary suspension without imminent danger, notice to the physician, or a subsequent hearing.

CONCLUSION

This Court should grant the Petition for Writ of Certiorari.

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608

Counsel for Amicus

Dated: November 12, 2009